

# Trauma-Focused, Present-Centered, Emotional Self-Regulation Approach to Integrated Treatment for Posttraumatic Stress and Addiction: Trauma Adaptive Recovery Group Education and Therapy (TARGET)

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*We describe the rationale and procedures for a trauma-focused, present-centered, emotion self-regulation model for concurrent treatment of posttraumatic stress disorder (PTSD) and substance use disorders: Trauma Adaptive Recovery Group Education and Therapy (TARGET). Based on a review of the clinical and research literatures relevant to models of psychotherapy for co-occurring PTSD and addiction, we develop a conceptual model and describe a skill set that has been operationalized in TARGET. Clinical vignettes with challenging cases are provided to illustrate the application of the TARGET model in individual and group psychotherapy of co-occurring PTSD and addiction.*

Although posttraumatic stress disorder (PTSD) is prevalent among adults in treatment for substance use disorders (SUD) (Triffleman, Marmar, Delucchi, & Ronfeldt, 1995), most adults in SUD treatment are neither evaluated for PTSD nor offered PTSD treatment despite voicing a clear preference for concurrent psychotherapy for PTSD and SUD (Brown et al., 2003). Moreover, there is preliminary evidence that SUD treatment recruitment and retention (Brown et al., 2003) and outcomes (Palacios, 1999) are adversely affected by undetected and untreated PTSD.

Effective treatments have been developed for PTSD (Foa, Keane &

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Friedman, 2001) and for addictions (Kadden, 1999). However, psychotherapy approaches for co-occurring PTSD and addiction are less well developed. In this article, we will describe the complicated interaction between PTSD and addiction, and identify the primary objectives for concurrent PTSD and addictions treatment. We will discuss the strengths and limitations of extant approaches to PTSD and addiction treatment in relation to each primary objective, and then describe the conceptual model and skill set taught by a new treatment model—Trauma Adaptive Recovery Group Education and Therapy (TARGET)—in order to illustrate points of complementarity with and departure from the alternative treatments. Finally, we will provide clinical examples to illustrate the application of TARGET.

### **THE COMPLEX INTERACTION OF PTSD AND SUBSTANCE ABUSE: IDENTIFYING TARGETS FOR TREATMENT**

The diagnosis of PTSD formally involves three symptom-based criteria: intrusive reexperiencing (unwanted trauma memories, reminders, and flashbacks), avoidance of reminders of past trauma and emotional numbing, and hyperarousal and hypervigilance (American Psychiatric Association, 1994).

The neurobiology of trauma and dissociation (Ford, 2005) provides a useful framework for understanding the interplay of these symptoms with each other and with addiction. The alterations in brain chemicals believed to underlie PTSD tend to be similar to, or complementary with, the neurobiological alterations associated with SUD, including the dysregulation of key neurotransmitters (e.g., dopamine, serotonin, norepinephrine) and neuropeptides (e.g., glucocorticoids, neuropeptide Y, substance P) in the body's central (brain) and peripheral (autonomic) nervous systems, which modulate stress reactivity (Jacobsen, Kosten, & Southwick, 2001). The core neurobiological alteration in PTSD is *hyperarousal*, a tendency for the brain and the body's nervous system to react in a rapid, extreme, and prolonged manner to stressors. In an attempt to modulate these intense physiological reactions, the individual often draws upon adaptive forms of anticipatory awareness (e.g., watchfulness for signs of external danger or bodily distress). If hyperarousal persists, the adaptive attempt to anticipate and prepare may escalate into a maladaptive preoccupation with even mild or remote signs of threat or bodily distress (*hypervigilance*). In order to reduce hyperarousal and to sustain hypervigilance, *avoidance* of people, places, activities, thoughts, emotions, or body sensations associated with threat or distress tends to occur. Avoidance is associated with severe

difficulties with the recognition and expression of emotions (*emotional numbing*), especially emotions involving intimacy, vulnerability, or trust in others (*social detachment*). As a result, survivors become unable to process and integrate trauma memories, leading to being flooded with unwanted memories (*intrusive re-experiencing*). When this persists the bodily dysregulation can lead the person to feel as if trauma is happening all over again (*flashbacks*).

Each of these features of PTSD can lead to substance use problems, including use of alcohol, street drugs, and prescription medications (Jacobsen et al., 2001; Triffleman, 2002). Exposure to trauma is not alone sufficient to lead to SUD, but PTSD may lead to SUD (or may cooccur with SUD as a result of other factors, e.g., impulsivity, social isolation) (Breslau, 2003). *Hyperarousal* can lead to attempts to reduce anxiety and tension through self-medication, or on the other hand to the use of stimulant drugs in order to maintain a state of high arousal. *Hypervigilance*, similarly, may be sustained by the use of drugs that artificially increase the ability to maintain alert watchfulness. Psychoactive substances may be used to reduce the distress associated with intrusive reexperiencing and to provide temporary forms of avoidance of traumatic memories and associated distress (i.e., self-medication). Emotional numbing and social detachment in PTSD may lead to the use of substances as a means of regaining the ability to feel pleasure or connection to other people. Posttraumatic stress disorder also often involves dysphoria, impulsivity, and social isolation, each of which can lead to SUD.

Moreover, SUD can exacerbate or complicate PTSD. Substances that increase or depress the body's arousal level and the interactive effects of brain neurotransmitters tend to directly or indirectly (e.g., through rebound effects) heighten hyperarousal and hypervigilance. Substances that have mood altering effects can increase hypervigilance, emotional numbing, and social detachment by inducing states of persistent dysphoria or anxiety. Substances that alter information processing can interfere with planful working memory and narrative autobiographical memory, thus leading to unwanted trauma memories that are fragmentary, confusing, and involuntary. The lifestyle associated with chronic SUD often includes engaging in activities and involvement with peer groups that increase the risk of exposure to traumatic stressors (e.g., violence, crime, abuse, accidents).

The goals of psychotherapy for PTSD and SUD thus, while not identical, are complementary. Increasing the ability to replace impulsive reactions with reflective reality-based decisions is critical to managing both

intrusive trauma memories and the cravings for substances and automatic behavior patterns that sustain addiction. In order to eschew avoidance (whether via substance use or other self-defeating behaviors) as a primary coping strategy, the individual must have skills that enable her to modulate intense (e.g., hyperarousal, intrusive re-experiencing; cravings for substances) and diminished (e.g., emotional numbing; disregard for personal safety and well-being) states of bodily and emotional activation. Planful decision making and effective emotion regulation require the ability to access long-term memory to draw upon past learning and short-term memory to formulate and follow-through with timely and organized immediate choices.

### **PSYCHOTHERAPY APPROACHES FOR PTSD AND ADDICTION**

Although there is a strong evidence base to support the use of cognitive behavior therapy (CBT) for treating PTSD, most studies of CBT for PTSD have excluded individuals with active SUD, so the applicability of this approach to the concurrent treatment of SUD and PTSD remains to be tested (Foa et al., 2000). Many people with co-occurring SUD and PTSD have suffered victimization trauma in childhood as well as in adulthood (Triffleman et al., 1995). Treatment for PTSD resulting from child abuse trauma requires attention to basic self-regulatory deficits (Herman, 1992). Indeed, Tarrier et al. (1999) excluded CSA survivors from their study of exposure and cognitive restructuring because of concern that these treatments would not address developmental sequelae. McDonagh-Coyle et al. (2005) found a high rate (43%) of premature dropout from an exposure-based therapy for adult survivors of childhood sexual abuse (the majority of whom had lifetime SUD histories, although none were currently using substances), but a low drop-out rate (5%) from a supportive social problem solving therapy—and comparable efficacy in reducing PTSD. However, when adult survivors of child abuse were provided with preparatory training in skills for affect management, CBT for PTSD was well tolerated and beneficial (Cloitre et al., 2002).

Turner et al. (1996) cite persistent dysfunctional beliefs and associated deficits in self-care skills as a complicating factor for the survivors of CSA with PTSD: high initial levels of anger (Foa, Riggs, et al., 1995), memories reflecting “mental defeat” or the absence of mental planning (Ehlers et al., 1998), an overall sense of alienation or permanent change following the trauma (e.g., feeling permanently tainted or damaged (Ehlers et al., 1998), and an inability to develop a coherent narrative recounting of trauma experiences in PE (Foa, Molnar, & Cashman, 1995). On the positive side,

participants in the McDonagh-Coyle et al. (2005) study who were able to experience and modulate strong emotions in therapy had positive outcomes in both the CBT and problem-solving treatments. Thus psychotherapists must address longstanding beliefs and dysregulated emotions when treating PTSD with survivors of childhood abuse. Interventions for the concurrent treatment of PTSD and SUD have taken several approaches to addressing this goal.

### MODELS FOR CONCURRENT PTSD AND SUD TREATMENT

Cognitive behavioral therapy only recently has been applied to PTSD with individuals in recovery from addiction. For example, a 16-session intervention combining prolonged exposure and cognitive restructuring with cocaine dependent adults reported promising results for completers, but a high (60+%) drop out rate (Brady, Dansky, Back, Foa, & Carroll, 2001). A 12-week partial hospital group CBT intervention ("Transcend," Donovan, Padin-Rivera & Kowaliw, 2001) reported clinically significant reductions in PTSD and alcohol and drug use that were maintained at 6- and 12-month follow ups. Assisted Recovery Trauma and Substances (ARTS; Triffleman, 2002), a 20-week, one-to-one therapy that first provides 11 sessions of CBT focused on substance abstinence and then 29 sessions of individualized and paced CBT for PTSD, resulted in similar improvement in PTSD symptoms and superior attendance and abstinence compared to CBT focused only on SUD.

Seeking Safety (SS; Najavits, 2002) is a manualized group intervention for women or adolescent girls with co-occurring PTSD and SUD that teaches more than 80 "safe coping skills" organized in a curriculum in which each session covers a defined topic with a presentation by the group leader and structured exercises to practice skills relevant to the topic (e.g., understanding and managing PTSD symptoms, anger; or guilt). Seeking Safety does not include discussion of specific trauma memories, but teaches skills for managing traumatic stress symptoms as they impact on overall life functioning and recovery from comorbid SUD. In a study with 27 women, Seeking Safety was comparable to relapse prevention and superior to addiction treatment as usual in reducing PTSD and SUD symptom severity and was superior to both other interventions in improvement in anxiety, depression, hostility, suicidality, and interpersonal problems (Najavits, 2002).

Trauma Recovery and Empowerment Model (TREM; Harris & Fallot, 2001) is an educational group intervention (like Seeking Safety) for women or men with co-occurring major mental illness, SUD, and PTSD, focusing

particularly on the cumulative effects of living with poverty and stigma following victimization trauma. Trauma Recovery and Empowerment Model is manualized, with versions ranging from a 4-session introduction to a 24-33 session group. Initially, TREM focuses on skills and knowledge for personal and relational awareness to address arrests in psychosexual development, and it provides a supportive (gender-separated) group milieu in which each survivor can disclose memories of trauma and overcome fear, grief, and shame in the form of telling her life story.

A recent multisite study of multicomponent treatment models for women with co-occurring psychiatric and addictive disorders and histories of exposure to violence included Seeking Safety and TREM at several sites. While no model-specific findings supported either approach specifically in relation to a usual care condition, "small but statistically significant" benefits were found in PTSD and mental health symptom reduction when the results were aggregated for both of these integrated PTSD/SUD psychotherapy approaches across all sites and interventions (Morrissey, Jackson, Ellis, Amaro, Brown, & Najavits, 2005, p. 1213). Despite differences in these models, their common focus on the psychotherapeutic resolution of both PTSD and SUD in women's current lives proved effective.

#### **KEY DIFFERENCES AMONG TREATMENT MODELS FOR CO-OCCURRING PTSD AND SUD**

Several conceptual and technical features distinguish the evolving treatment models for co-occurring PTSD And SUD.

Cognitive Behavioral Therapy approaches focus on reducing anxiety and avoidance related to trauma memories (Foa & Kozak, 1998), and emphasize correcting dysfunctional cognitions to reduce intrusive symptoms of reexperiencing, emotional numbing, hyperarousal, and hypervigilance. (Brady et al., 2001; Donovan et al., 2001; Mueser et al., 2002; Najavits, 2002; Triffleman, 2002). Although CBT theorists recognize that maladaptive *information processing* must be dealt with to modify maladaptive beliefs (Brewin & Holmes, 2003; Foa & Kozak, 1998), a systematic approach to enhancing information processing for PTSD or PTSD/SUD have not developed for CBT interventions.

Other approaches to PTSD therapy emphasize helping survivors regain "authority over the remembering process" (Harvey, 1996, p. 11) and regaining a sense of trust in themselves and in healthy relationships (Harris & Fallot, 2001; Herman, 1992) by telling their personal story (or narrative) and thereby "making meaning out of trauma" (Harvey, 1996, p. 13). The

goal is not to reduce avoidance or to extinguish maladaptive fear (as in CBT), but to develop or regain a sense of empowerment, personal identity and worth, secure involvement in healthy relationships, and realistic satisfaction in life and hope for the future. Similar to some CBT models (skills training in affective and interpersonal regulation with prolonged exposure [STAIR-PE], Seeking Safety), these self/relational approaches begin by helping clients learn or strengthen skills for healthy bodily self-care and psychological and relational safety. Cognitive Behavioral Therapy models also aim to help clients create positive personal narratives, healthy relationships, and self-worth, but view these as a byproduct of reducing anxiety, whereas self/relational models view narrative and self-actualization work as the means rather than the ends of reducing anxiety. However, self/relational models have not developed a systematic therapeutic protocol grounded in theory and research to guide therapists and clients in doing personal/trauma narrative work.

Both CBT and the self/relational approaches to PTSD/SUD treatment include interventions designed to enhance social problem solving skills and affect regulation skills (Ford, Courtois, van der Hart, Nijenhuis, & Steele, 2005). This is particularly important with survivors of early childhood interpersonal trauma who are at risk for extreme dysregulation of emotion (e.g., rage, despair, terror), information processing (e.g., severe dissociation), bodily functioning (e.g., debilitating somatization), and relationships (e.g., enmeshed or explosive) (Ford, 1999; van der Kolk et al., 1996).

Cognitive Behavioral Therapy focuses on helping clients identify and manage their reactions to trauma-related triggers in their current lives (Sharkansky, Brief, Peirce, Meehan, & Mannix, 1999; Triffleman, 2002), and replacing maladaptive coping styles with effective problem solving and assertiveness skills (Donovan et al., 2001; Najavits, 2002; Triffleman, 2002). Self/relational models instead rely upon therapeutic activities designed to build self-awareness, self-esteem, personal boundaries, and healthy intimacy (Harris & Fallot, 2001; Pearlman & Saakvitne, 1995). However, no PTSD/SUD model has explicated a systematic set of steps that clients can use to guide them in regulating intense emotions and solving social problems while maintaining sobriety. Additionally, none of these models provides a practical framework for understanding and for managing trauma memories and affect dysregulation while also strengthening sobriety. The treatment to be described in this paper is based upon just such an organizing framework, which was developed to build upon and extend the strong base provided by other models for concurrent psychotherapy of SUD and PTSD.

## TRAUMA ADAPTIVE RECOVERY GROUP EDUCATION AND THERAPY (TARGET)

Trauma adaptive recovery group education and therapy (TARGET) is a manualized group and one-to-one psychotherapy that provides

- education about the biological and behavioral underpinnings of PTSD and SUD,
- guidance in applying an integrated set of information/emotion processing and self-regulation skills to current life experiences, and
- an experiential component through the development an autobiographical narrative that incorporates, but does not primarily focus upon, trauma, PTSD, and SUD. TARGET was first developed in private practice and community mental health settings for adults with co-occurring mental illness and PTSD. For this population it was both clinically indicated and feasible to deliver TARGET as a closed- or open-ended treatment lasting between six months and several years. In order to match the logistics of SUD treatment, a briefer 9-session TARGET version was developed and was found to be associated with significantly better abstinence self-efficacy than an enhanced treatment-as-usual condition in a randomized effectiveness study (Frisman, Ford, & Lin, 2005).

### TARGET'S ORGANIZING FRAMEWORK

TARGET focuses each client's attention on the core values and hopes that have been the basis for her lifelong project of evolving a personal identity (i.e., self-definition, self-esteem, and self-efficacy) and meaningful and worthwhile relationships. Intrusive trauma memories and hypervigilance are reframed as occurring not because the person did not cope adequately with trauma, but because the survivor coped so effectively that now she has an internal biological alarm system that is adjusted for trauma but not for ordinary living. Therefore, rather than attempting to have the client become desensitized to intense emotions, or thinking more rationally and relaxing instead of being hypervigilant when experiencing intrusive trauma memories, the goal is for the client to learn ways to *prepare for, and productively process, current trauma reminders* (internal and external) and how to reset the body's survival alarm appropriately to current life circumstances.

TARGET focuses on resilience by shifting clients' attention to the meaningful reactions, feelings, thoughts, goals, and choices that are occur simultaneously with SUD and PTSD symptoms. Each symptom involves effort (even if it seems to be automatic) and skillful planning and action



## Trauma Adaptive Recovery Group Education and Therapy (TARGET)

Table 1. THE TARGET FREEDOM STEPS

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- **Focus** — to reduce anxiety and increase mental alertness
  - **Recognize** — specific stress triggers
  - **Emotions** — identify primary feelings
  - **Evaluate** — primary thoughts/self-statements
  - **Define** — primary personal goal(s)
  - **Option** — identify one choice that represents a successful step toward the primary goal(s) that the individual actually accomplished during a current stressful experience
  - **Make a contribution** — recognize how that option had the added benefit by reflecting the person's core values and made a difference in others' lives.
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(even if it has become an impulsive reaction). The goal of treatment is to rediscover the personal goals, choices, and abilities that have been obscured by the problematic aspects of PTSD and SUD symptoms—not to “get rid of” the symptoms, or to simply “substitute” adaptive ways of coping, but to find and rebuild adaptive skills that the survivor possesses and values within her/himself. The goal is to validate strengths rather than focusing on failings or deficits, and to engage clients in a constructive self-directed examination of the problematic aspects of symptoms. This is done with a blend of empathic validation (i.e., identifying problematic symptoms as “alarm” reactions in which the brain/body is attempting to protect the person from potential threats, real or perceived, in automatic ways that were adaptive in surviving trauma) and strengths-based, client-centered reframing (i.e., exploring alternative choices that already exist and reflect the person's fundamental core emotions, beliefs, goals, and values, but which are obscured by automatic “alarm” reactions).

TARGET is organized around a skill sequence that is described by an acronym, FREEDOM, a mnemonic tool (see Table 1). The FREEDOM skill sequence mirrors the neurobiology of adaptive development (Ford, 2005) and the three phases of PTSD treatment (Ford et al., 2005).

Phase 1 involves stabilization and self-regulation via *Focusing* (“F”). Focusing is taught as a three-step process that can be done in a matter of seconds, but requires repeated practice to be well-rehearsed and available when stress reactions are experienced. The three steps are summarized by the familiar code for calls for help, *SOS*. The first “S” stands for *Slow down*: pause, take a breath, clear your mind, and inhibit impulsive actions. The “O” stands for *Orient*: pay attention to what your five senses are telling you about your body (especially healthy feelings) and your environ-

ment (especially things/people that are interesting). The second “S” stands for Self-check: clients learn to make rapid ratings of current stress and perceived personal control on two 10-point scales. The purpose of SOS is to provide a practical, easily recalled self-cue (or cue from other people, such as friends or counselors who can suggest doing an “SOS”) that interrupts reactive/impulsive thinking and action and facilitates simple cognitive processing.

Phase 2 includes trauma processing via Recognizing (“R”) specific triggers for “alarm” reactions and the “reactive” Emotions (“E”), and cognitive Evaluations (“E”), goal Definitions (“D”), and behavioral responses or Options (“O”)—the “REEDO” in FREEDOM—in the context of therapeutic examination of *current* life experiences, with past experiences (traumatic, as well as other, formative events or relationships) as a background for meaning-making (Harvey, 1996) rather than as the principal focus. The TARGET framework is an easily understood, remembered, and utilized *sequence* of steps for information and emotion processing that incorporates the trauma-based processing of PTSD, but principally, it shifts the person’s focus to more self-reflective processing. In this respect, TARGET is complementary with other skills-based psychoeducation models for PTSD (e.g., Cloitre et al., 2002; Resick et al., 2002), SUD (e.g., Kadden, 2001), co-occurring PTSD and SUD (e.g., Donovan et al., 2002; Mueser et al., 2002; Najavits, 2002), or related relational, behavioral, and characterological problems, such as Dialectic Behavior Therapy ([DBT]; Linehan, 1993). Skills taught in these models, such as mindfulness and distress tolerance (Linehan, 1993), grounding (Najavits, 2002), and abstinence violation management (Kadden, 1999), are potentially valuable tactics for managing urges, agitation, dysphoria, or risky impulses. The FREEDOM sequence additionally provides a systematic step-by-step model for simultaneously addressing addiction and PTSD based upon the research literature on the psychobiology of trauma and self-regulation (Ford, 2005). No claim is made that the FREEDOM steps map exactly onto the trauma survivor’s neurobiology or affect/information processing. However, the FREEDOM sequence provides an organizing template that therapists and clients can use as a proactive sequential approach to deploying self-regulation, information processing, and relational skills, in order to simultaneously address PTSD and SUD by: (1) managing triggered stress reactions, and (2) enhancing the clarity of thought, feeling, and relatedness.

Phase 3 involves an extension of therapy by incorporating the learning from Phases 1 and 2 into work on the client’s overarching lifestyle, values,

goals, and plans. This is accomplished by revisiting the third through fifth **FREEDOM** steps and assisting the client in identifying alternatives to the and goal(s) that are what the client feels, thinks, and aims for in life when not caught up in “alarm” reactions. This phase involves the careful identification of actions the client *already is taking when experiencing triggered “alarm” reactions* that the client views as positive steps (however imperfect or partial) toward her **main** goals. Lastly, Phase 3 includes repeated discussions of how, from the client’s point of view (with guidance from the therapist or, in group therapy, from group members), she or he is making a contribution to the people and values that are most important to her or him by taking those steps toward **main** goals.

### THE TARGET CLINICAL INTERVENTION

There are three core therapeutic components in the TARGET clinical intervention. The first is education, which provides a novel definition and description of PTSD as a biological change in the body’s “alarm” system that occurs as the result of automatic and highly adaptive reactions to a threat to the individual’s (or a significant other’s) survival. The role of the peripheral (e.g., autonomic) and central (e.g., brain stem, limbic, anterior cingulate, prefrontal cortex) nervous systems (Ford, 2005) in responding to danger and in seeking pleasure and avoiding distress is illustrated with graphics and metaphorical examples (e.g., subcortical neural circuits as the brain’s “alarm” and “reward” systems; limbic and prefrontal circuits as the brain’s “in box” and “decision-maker”) that make the neurobiology of PTSD and SUD accessible to laypersons. The concept of a biological “survival alarm” that becomes sensitized, and therefore highly reactive, to what appear to be minor stressors or substance use cues/contexts (“triggers”) helps participants to make sense of the varied symptoms of PTSD, SUD, and associated socioemotional problems (e.g., rage, panic, dysphoria, denial, dissociation). This helps clients relate to their own experience in a reframed version that emphasizes that these normal reactions to abnormal circumstances are healthy survival adaptations that have become highly reactive due to trauma.

With this introduction, clients (who typically have sketchy or superficial information about the nature, origins, and causes of the persistence of PTSD and SUD symptoms) often become very interested in learning how they can gain greater control over PTSD and SUD by better recognizing and managing the body’s “alarm” reactions. Therefore, the second core component in TARGET is the teaching and guided practice of the **FREEDOM** skill sequence for managing traumatic stress symptoms. The

FREEDOM protocol incorporates basic safety and self-management skills (e.g., Najavits's [2002] "grounding" skills) in a teaching sequence that begins with these skills before focusing on trauma-related emotion processing and autobiographical reconstruction (Cloitre et al., 2002). The FREEDOM model provides a practical template for reflective examination of current stressful experiences with a self-monitoring to assist clients in recognizing how the skills can "reset" the body's alarm system.

The FREEDOM skill sequence is used primarily as a prototype for reexamining recent stressful experiences, but also, it can serve as a guide for safely examining trauma memories. Trauma memory work is undertaken only if the memory is troubling the client currently *and* if the client and clinician judge that a clearer and more organized understanding of the traumatic event(s) and the antecedents and consequences will help the client in coping with current stressors and symptoms. Trauma memory recollection and disclosure, therefore, is not an automatic or required component in TARGET. It is an option pursued only at the client's behest and preferably after the FREEDOM skill sequence has been well learned and extensively practiced in examining current sub-traumatic stressful experiences. The one exception to this rule is when a client feels flooded with intrusive memories during an early TARGET session. This is not the norm but occurs often enough to warrant clinical preparation. In this case, the TARGET therapist helps the client regain a sense of present safety and focus using the SOS paradigm. This is achieved either by exploring potential triggers that elicit the intrusive memories (i.e., shifting to work on the "R" step of recognizing specific triggers) and how the client's reactions are an appropriate posttraumatic alarm state, or by helping the client to identify key, specific elements in the memory (again paralleling the FREEDOM steps, including triggers and primary emotions, thoughts, or goals) that increase reflective distance from the memory and enhance the client's ability to experience the memory as organized and manageable rather than toxic and overwhelming.

Some clients choose not to reexamine trauma memories in detail. Others select key memories and develop a personal plan for reexamining and disclosing these memories in a way that enhances their sense of "mastery" of their memories (Harvey, 1995) and emotions (Gleiser et al., in review) and control of their body and their relationships (Harris & Fallot, 2001). Typically, these clients use FREEDOM skills to address intrusive reexperiencing symptoms by focusing on greater awareness and control of bodily reactions, emotions, and thoughts triggered by current

stressors and by refocusing core goals and effective choices during or after an unwanted memory of past traumas.

Past trauma memories tend to be reexamined in individual therapy to provide the client with privacy and the counselor's uninterrupted attention—as well as to prevent the contagion of distress that can occur when clients disclose detailed trauma memories in group therapy. As noted above, if a client experiences an unwanted memory or other intrusive reexperiencing symptoms in group sessions, or if she chooses to disclose a memory in a group session, the group leaders use the FREEDOM protocol to help the client (and all other group members) refocus on their immediate reactions, emotions, and thoughts and on identifying current or recent triggers that may have elicited the unwanted memory or symptoms.

When examining a specific trauma memory in individual counseling, the FREEDOM skill sequence is used to assist the client in developing a more complete reconstruction of not only what happened but also (a) important event(s) that preceded or led up to the traumatic experience, (b) the event(s) and the client's reactions and coping strategies in the minutes, hours, and days after the focal trauma, and (c) personal goals, choices, and accomplishments before, during, and after the trauma that the client typically has overlooked or discounted. The goal of the FREEDOM method is not to change the valence of trauma memories or stressful current experiences from negative to positive, but instead to increase the range, complexity, and contextualization of the client's memory of the recent or past events so that there is a greater balance of coexisting (rather than fragmented or compartmentalized) negative and positive elements in the recollection.

The third core component in TARGET is an experiential exercise designed to enable clients to reengage autobiographical or narrative information processing and memory by safely accessing, containing, and organizing emotionally charged personal memories. This is done by using a nonverbal creative arts modality (Johnson, 2000) that enables a client to incrementally construct a picture of her life (i.e., the "Personal Lifeline"; Ford & Stewart, 1999). The Lifeline exercise is interspersed throughout several sessions so that each client's emergent personal story is reconstructed within a growing context of personal efficacy, autonomy, relatedness, and safety that enables the survivor to organize cognitively and affectively process the previously fragmented and overwhelming memories of trauma and other important positive and negative life experiences.

**THERAPEUTIC ALLIANCE IN TARGET: REPAIRING DISORGANIZED FORMS OF ATTACHMENT**

TARGET is designed to provide a vehicle for the development of a strong therapeutic alliance between providers on the treatment team and each client. The structured education, skills sequence, and autobiographical reconstruction components of TARGET provide the tools for clinicians and case managers who work with trauma survivors that enable them to serve as role models for adaptive emotion self-regulation in the context of an emotionally charged but secure and reliable therapeutic relationship. With these tools the providers can teach subtle skills for self-regulation both through a nonverbal process of coregulation (Schoore, 2001) as well as through the overt educational, skill building, and creative arts modalities that provide the obvious structure for TARGET.

**CULTURAL, LINGUISTIC, AND GENDER ADAPTATIONS**

TARGET was developed in pilot work with diverse client populations that include women and men, hearing and non-hearing individuals, ranging in age from 10 years to more than 70 years old. Ethnocultural backgrounds included individuals who self-identified as Black (African and Caribbean-American), Latino/Latina (Puerto Rican, Central American, and Mexican/Chicano), Native American, and Caucasian (American, European, and Middle Eastern). Clinicians and case managers teaching and carrying out therapy with TARGET have developed a number of adaptations in the wording, examples and metaphors, and even the tangible materials (e.g., laminating each letter from FREEDOM on cards suitable for display on household cabinets, appliances, or bulletin boards; modifying educational handouts with enhanced graphics for deaf clients) to make the curriculum accessible to clients from this wide variety of backgrounds and heritages. TARGET also has been formally translated and field tested by psychotherapists in Spanish, Dutch, and Hebrew. The examples and exercises in TARGET are designed to accommodate the differing interests, preferences, and activities of women and men—with no assumption of there being any *a priori* (stereotyped) activities that are purely gender specific.

**RELATIONSHIP TO SUD TREATMENT**

TARGET is designed to complement and not compete with or replace all other SUD treatment modalities (e.g., support groups, addiction education classes, relapse prevention, self-help and social support meetings). TARGET has been used as the primary therapy modality for both SUD and PTSD treatment in some instances, although this is not necessary. The

alarm metaphor and FREEDOM skill sequence have been adopted in many SUD treatment groups as a way to understand addictive urges/cravings and to work mindfully toward sobriety.

### CASE EXAMPLES OF TARGET IN CLINICAL PRACTICE

#### A WOMAN IN RECOVERY FROM ADDICTION, CHILD ABUSE, AND DOMESTIC VIOLENCE

Cathy, a 33 year-old a European American woman, was referred to a TARGET group by her clinician several weeks after she entered treatment for her polysubstance abuse (alcohol, crack cocaine, heroin). Cathy was talkative and friendly, and rapport was easily established by the African-American TARGET assessor. During the course of the trauma assessment, Cathy shared her complex trauma history encompassing childhood sexual and physical abuse and childhood neglect; she reported a history of several rapes, both acquaintance and stranger, domestic violence, and incidents of physical assault (robbery). Cathy reported that she was currently living with her boyfriend of several months. She also reported being unhappy in the relationship, feeling as though the verbal abuse she suffered at home was extremely similar to the physical abuse she remembered at the hands of others. She met diagnostic criteria for major depression, PTSD, and complex PTSD (Ford, 1999).

Cathy actively participated in group sessions from the beginning of her therapy. She immediately found the psychoeducational concepts resonant with her personal experience, and spontaneously said in the first session that she felt this group offered her a way to understand and deal with symptoms that she felt she had never really understood. She compared it to being able to see through a car windshield while driving rather than "flying blind" and trying to "run as fast as I can", without a sense of purpose or direction. She appeared comfortable sharing personal experiences about her journey of recovery with the group, but did not dwell on specific past traumas. She attended the group's first five sessions, and she reported success using many of the skills introduced to identify current substance use triggers and trauma reminders. When Cathy missed the sixth session, the group leaders followed up with her primary clinician. Cathy had failed to show up for her day-treatment program for several weeks, and her therapist was sure that she had relapsed. When Cathy returned for treatment several weeks later, she entered as an inpatient and reported having had a several week relapse and feeling suicidal. However, upon her return she immediately contacted one of the group leaders and asked if she could return to the TARGET group sessions.

Cathy subsequently enrolled in a second TARGET group, and although she was much quieter during sessions, she was attentive. She offered suggestions to help explain the FREEDOM model and experiential exercises, but reported that this time she wanted to concentrate on really understanding her history and its relationship to her addiction. She asked questions, completed her homework, and received support from her primary clinician outside of group. During her inpatient stay at the treatment center, Cathy separated from her long-term boyfriend. She shared this information with the group, explaining she had begun to compare her SOS (Focusing) self-checks when she was with her boyfriend and when she was separated from him. She found that her level of subjective distress always was higher when with him, and this evidence motivated her to separate from her boyfriend to concentrate on treatment and truly gain "FREEDOM" from her past history. Cathy did very well in treatment, and completed the TARGET group abstinent from substance use. She became involved in sobriety support activities (for the first time in her life she had a sponsor), reduced reactivity, and increased personal control when she encountered triggers (e.g., messages from her ex-boyfriend pleading with or threatening her). She was invited to return as a peer leader after she completed the groups, but was unable to do so because she acquired a job and a new apartment. Her new home was a considerable distance from the treatment center and because she was unable to drive a car due to past DUI convictions, attendance at the groups would have been a stressor rather than a support to her continued recovery. In the graduation session she reported that she was using the FREEDOM skills and teaching them to her friends, family, her sponsor, and Narcotics Anonymous group members. She noted that this was her way of continuing her own recovery and making a contribution (the "M" in FREEDOM) to the people in her life.

#### **A MAN IN RECOVERY FROM ADDICTION AND COMMUNITY VIOLENCE**

Roberto, while living in a supported housing apartment for low-income individuals with severe mental illness and addictions, was enrolled in a TARGET group in a diversion program for criminal offenders with substance abuse problems. He gave a sketchy history, describing physical and sexual abuse by his mother when he was a young boy, witnessing her having sex, and being assaulted while she was prostituting. He never knew his father, and he grew up playing the alternate roles of his mother's protector and confidante or "black sheep", who was beaten by his mother for being "unruly". He gained a reputation as a "tough guy" at school



(until dropping out in ninth grade) and on the city streets. He now showed signs of cognitive impairment consistent with mild retardation, possibly due to multiple concussions suffered in fights and from more than 30 years of heavy polysubstance use. Roberto was skeptical about TARGET, or any group for that matter, reporting that he didn't like to "let other people know my business" and that he didn't think anything, except his own willpower, could help him with fits of rage and depression.

Initially, Roberto found the psychoeducation difficult to understand. He was overwhelmed by the new ideas and by the input of the other group members as they gave personal examples of their "alarm" reactions and stress triggers. The group leaders carefully slowed down the pace of education and asked every group member to take a turn talking about each core concept. With this structure, Roberto became more relaxed and attentively listened to other group members, insightfully describing his own stress triggers, emotions, thoughts, and goals. He was especially enthusiastic about getting more focused on his personal goals and his positive choices ("O" or Options in the FREEDOM model), and led the group in developing a list of goals and options that became a new handout for this and subsequent TARGET groups. He felt honored to receive the "respect" of the group members and leaders, and said that this strengthened his sense of personal control by supporting his true *machismo* without him having to be the "bad guy". Roberto completed all nine sessions, including developing a Lifeline that poignantly showed his dream of having a family and being both a son and a father. He was able to use the FREEDOM skills to catch his self-critical thoughts in relation to his mother and to be more assertive with her when she was angry or irritable—now viewing her reactions as "just her stress alarm, not me being a bad son." He also decided to make contact with his 19-year-old son, who Roberto had not seen since the child was three years old, and who, as a young adult, was in prison for violent crimes similar to Roberto's own. The group provided Roberto with a venue for support and a place to plan for and debrief after two phone calls to his son, which Roberto considered to be a turning point in his life and a contribution that he had always wanted to make.

### USE OF THE LIFELINE EXERCISE IN A WOMEN'S TARGET GROUP

The Lifeline Exercise was introduced to a TARGET group at the end of the fifth session as an activity that the group members would begin the following week. The five women participants (two Latinas, one Caribbean-American, and two Caucasians) had immediate, strong reactions to the

prospect of completing a Lifeline, appearing distrustful because one exercise involved explicitly disclosing and charting their past experiences in a way that reminded several members of extremely stressful past legal proceedings. Group members were able to say that they were fearful that this experience would be distressing for them. Their concerns were discussed supportively and the exercise was explained again, with a particular emphasis on the inclusion of the present and future so that this would be a picture of their lives, not a report of past traumas or mistakes. Nothing too painful to disclose had to be aired. The participants could choose when and how to focus on positive or negative memories and experiences as a way of gaining more control in their lives and not repeating past experiences of feeling judged, punished, or victimized. Group members decided to try the exercise with the understanding that if it was unpleasant they could stop and change or discuss the exercise.

The following week, four women returned for group. Materials were laid out and the exercise reexplained. Participants were reminded that they could use poetry, photographs, or swatches of color to represent anything in their Lifeline. Group leaders informed participants that the Lifeline did not need to be linear (as in timelines), but could take any shape. The women began tentatively, talking softly with each other to see what the each would do. They worked on their lifelines for 45 minutes. Periodically the group leaders checked-in with the participants and asked for feedback about the process. There was little comment, and the women seemed increasingly absorbed in their creations. After 45 minutes, the women were asked to stop and help put away the materials. Surprisingly, given the initial reluctance, each did so very slowly. The group circle was reformed and members were asked about their experience with the lifeline. The response was overwhelmingly positive and different for each woman.

One woman enjoyed arts and crafts and painting as a form of relaxation, so she enjoyed using different materials to express herself. She chose to focus on the present and the parts of her life that were both good and challenging. Another client reported that she focused on the past, finding positive memories from her childhood. Before beginning the project, she anticipated that the memories would consist mostly of spending time by herself, but she was surprised that in many of the memories she represented a close friend who was a refuge during her traumatic childhood. A third client also reported enjoying the exercise more than she had anticipated. She also focused on the present, but only on positive aspects. The fourth client chose to focus on the future with her daughter. Each participant received praise and statements of sincere appreciation from

other group members. The group leaders thanked the entire group for their honesty and willingness to stay safe as they risked looking carefully at their lives, despite their very understandable anticipatory anxiety.

In each of the remaining group sessions, group members asked that time be set aside for them to add to their Lifelines. They explained that the exercise reduced their alarm reactions by helping them to know themselves and understand how they became who they were. Several members commented that this was the first chance they had had to safely look at who they were—other than just trauma survivors—while not denying the impact trauma had had on them.

### CONCLUSION

As one of several promising new models of integrated psychotherapy for co-occurring PTSD and SUD, TARGET provides psychotherapists with educational, behavioral, and experiential tools that engage clients with complicated, comorbid PTSD/SUD in a process of therapeutic self-reflection and change that addresses PTSD and SUD simultaneously. TARGET is a flexible template that can be utilized in group psychotherapy, as illustrated by the case examples, as well as in individual or conjoint couples/family therapy. By reframing PTSD and SUD as sharing a common dilemma of biologically based, but modifiable, “alarm” reactions, TARGET makes both the disorders and therapy transparent and manageable for therapists as well as for clients.

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